		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031757

Facility Name: WEST MAIN NURSING HOME

Address: 1224 WEST MAIN STREET (Number) MASCOUTAH (City) 62258 (Zip Code)

County: ST CLAIR

Telephone Number: 618-566-7327 **Fax #** ( )

IDPA ID Number: 0031757

Date of Initial License for Current Owners: 12/23/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** 636-394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/03 to 9/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JAMES J GIARDINA
(Title) PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DARRYL E BUEKER, CPA
(Firm Name & Address) BKD, LLP
PO BOX 1190; SPRINGFIELD, MO 65801-1190
(Telephone) 417-865-8701 Fax # 417-865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,444	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	34	TOTALS	34	12,444	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,733	464	306	9,503	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,733	464	306	9,503	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.37%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/23/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/23/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/03 Fiscal Year: 9/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	59,204	2,487	2,073	63,764		63,764		63,764			1
2	Food Purchase		37,133		37,133		37,133	(52)	37,081			2
3	Housekeeping	30,090	4,517		34,607		34,607	69	34,676			3
4	Laundry	16,704	6,065	30	22,799		22,799		22,799			4
5	Heat and Other Utilities			23,848	23,848		23,848		23,848			5
6	Maintenance	7,888	8,880	8,789	25,557		25,557	135	25,692			6
7	Other (specify):*											7
8	**TOTAL General Services**	113,886	59,082	34,740	207,708		207,708	152	207,860			8
	B. Health Care and Programs											
9	Medical Director			5,350	5,350		5,350		5,350			9
10	Nursing and Medical Records	360,935	19,911	43,806	424,652	(1,143)	423,509		423,509			10
10a	Therapy	19,396		6,655	26,051		26,051		26,051			10a
11	Activities	24,925	5,104	2,964	32,993		32,993		32,993			11
12	Social Services	15,794	15	942	16,751		16,751		16,751			12
13	Nurse Aide Training											13
14	Program Transportation			105	105		105		105			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	421,050	25,030	59,822	505,902	(1,143)	504,759		504,759			16
	C. General Administration											
17	Administrative	39,248			39,248		39,248	4,898	44,146			17
18	Directors Fees											18
19	Professional Services			15,233	15,233		15,233	(10,884)	4,349			19
20	Dues, Fees, Subscriptions & Promotions			3,858	3,858		3,858	(1,589)	2,269			20
21	Clerical & General Office Expenses		1,884	11,245	13,129		13,129	19,013	32,142			21
22	Employee Benefits & Payroll Taxes			103,672	103,672		103,672	3,753	107,425			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,514	1,514		1,514	1,286	2,800			24
25	Other Admin. Staff Transportation							91	91			25
26	Insurance-Prop.Liab.Malpractice			23,708	23,708		23,708	29	23,737			26
27	Other (specify):*											27
28	**TOTAL General Administration**	39,248	1,884	159,230	200,362		200,362	16,597	216,959			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	574,184	85,996	253,792	913,972	(1,143)	912,829	16,749	929,578			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WEST MAIN NURSING HOME #0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,675	5,675		5,675	12,833	18,508			30
31	Amortization of Pre-Op. & Org.							78	78			31
32	Interest							30,542	30,542			32
33	Real Estate Taxes			5,706	5,706		5,706		5,706			33
34	Rent-Facility & Grounds			30,600	30,600		30,600	(26,983)	3,617			34
35	Rent-Equipment & Vehicles			1,480	1,480		1,480	786	2,266			35
36	Other (specify):*											36
37	**TOTAL Ownership**			43,461	43,461		43,461	17,256	60,717			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			18,666	18,666		18,666		18,666			42
43	Other (specify):* **LAB/RX**					1,143	1,143		1,143			43
44	**TOTAL Special Cost Centers**			18,666	18,666	1,143	19,809		19,809			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	574,184	85,996	315,919	976,099		976,099	34,005	1,010,104			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,250)	21		18
19	Entertainment				19
20	Contributions	(60)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(857)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(779)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,582)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	40,587	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 40,587		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 34,005		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		81	10.2	42
43	Prescription Drugs	X		1,062	10.2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,143		47

STATE OF ILLINOIS

WEST MAIN NURSING HOME

ID# 0031757

Report Period Beginning: 10/1/03

Ending: 9/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(52)	0	0	0	0	0	0	0	0	0	0	(52)	2
3	Housekeeping	0	0	69	0	0	0	0	0	0	0	0	69	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	135	0	0	0	0	0	0	0	0	135	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(52)	0	204	0	0	0	0	0	0	0	0	152	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	4,898	0	0	0	0	0	0	0	0	0	4,898	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(10,884)	0	0	0	0	0	0	0	0	0	(10,884)	19
20	Fees, Subscriptions & Promotions	(1,636)	0	47	0	0	0	0	0	0	0	0	(1,589)	20
21	Clerical & General Office Expenses	(3,310)	22,323	0	0	0	0	0	0	0	0	0	19,013	21
22	Employee Benefits & Payroll Taxes	0	3,753	0	0	0	0	0	0	0	0	0	3,753	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,286	0	0	0	0	0	0	0	0	0	1,286	24
25	Other Admin. Staff Transportation	0	91	0	0	0	0	0	0	0	0	0	91	25
26	Insurance-Prop.Liab.Malpractice	0	0	29	0	0	0	0	0	0	0	0	29	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,946)	21,467	76	0	0	0	0	0	0	0	0	16,597	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,998)	21,467	280	0	0	0	0	0	0	0	0	16,749	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	12,833	0	0	0	0	0	0	0	0	0	12,833	30
31	Amortization of Pre-Op. & Org.	0	78	0	0	0	0	0	0	0	0	0	78	31
32	Interest	(1,584)	32,126	0	0	0	0	0	0	0	0	0	30,542	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(26,983)	0	0	0	0	0	0	0	0	0	(26,983)	34
35	Rent-Equipment & Vehicles	0	786	0	0	0	0	0	0	0	0	0	786	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,584)	18,840	0	0	0	0	0	0	0	0	0	17,256	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,582)	40,307	280	0	0	0	0	0	0	0	0	34,005	45

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	MARKA NURSING HOME	MASCOUTAH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		COMMUNITY CARE CENTER OF MONMOUTH	MONMOUTH	CARE CENTERS,		
				INC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	BUILDING RENT	$ 30,600	JAMES J GIARDINA	100.00%	$	$ (30,600)	1
2	V	30	DEPRECIATION		JAMES J GIARDINA	100.00%	12,833	12,833	2
3	V	32	INTEREST		JAMES J GIARDINA	100.00%	32,126	32,126	3
4	V	31	AMORTIZATION		JAMES J GIARDINA	100.00%	78	78	4
5	V	19	HOME OFFICE	11,640	COMMUNITY CARE CENTERS, INC	100.00%		(11,640)	5
6	V	34	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	3,617	3,617	6
7	V	35	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	786	786	7
8	V	17	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	4,898	4,898	8
9	V	21	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	22,323	22,323	9
10	V	22	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	3,753	3,753	10
11	V	19	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	756	756	11
12	V	24	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	1,286	1,286	12
13	V	25	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	91	91	13
14	Total			$ 42,240			$ 82,547	$ * 40,307	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	HOME OFFICE	$	COMMUNITY CARE CENTERS, INC	100.00%	$ 135	$ 135	15
16	V		20	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	47	47	16
17	V		26	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	29	29	17
18	V		3	HOME OFFICE		COMMUNITY CARE CENTERS, INC	100.00%	69	69	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 280	$ * 280	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	JAMES J GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	1	2.00	SALARY	$ 2,178	17.7	1
2	DOROTHY GIARDINA	VICE PRES		0.00	NONE	1	2.50	SALARY	1,452	17.7	2
3	BETTY HUGHES	SECRETARY		0.00	NONE	1	2.17	SALARY	1,268	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 4,898		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COMMUNITY CARE CENTERS, INC
Street Address: 312 SOLLEY DRIVE - REAR
City / State / Zip Code: BALLWINL, MO 63021
Phone Number: (636-394-3000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CTR						4,943,474	193,706	2
3		ST GENEVIEVE CARE CTR						2,223,147	87,113	3
4		CCC OF LEMAY						2,169,904	85,028	4
5		SALEM CARE CENTER						1,723,343	67,529	5
6		MONMOUTH NH						1,843,105	72,221	6
7		MAR-KA NH						2,429,478	95,199	7
8		WEST MAIN NH						964,459	37,792	8
9		CCC OF SENECA						2,519,153	98,712	9
10		MT VERNON PLACE CARE						2,628,281	102,990	10
11		COUNTRY VIEW NH						1,855,955	72,726	11
12		MERAMEC NH						2,465,827	96,623	12
13		SEVILLE CARE CENTER						2,348,996	92,044	13
14		SALEM RES CARE						479,605	18,794	14
15		BOSS RES CARE						123,142	4,825	15
16		CARL JUNCTION RES CARE						581,447	22,784	16
17		MT VERNON RES CARE						343,890	13,475	17
18		SENECA HOME PLACE						406,456	15,927	18
19		HUDSON HOUSE						433,115	16,972	19
20		MAPLE GROVE LODGE						2,853,434	111,812	20
21		CCC OF AURORA						3,845,678	150,692	21
22		BARRY COMMUNITY CARE						2,146,748	84,121	22
23		COMMUNITY IN HOME						519,992	20,376	23
24										24
25	TOTALS					$	$		$ 1,561,461	25

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	3,690	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	5,346	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,656	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4,050	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	5,706	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	4,607	8
	2000	4,678	9
	2001	4,843	10
	2002	4,936	11
	2003	5,346	12

ACCRUAL - 5,346 x 9/12 = 4,010 + MISC DIFF 40 = 4,050

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEST MAIN NURSING HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0031757

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31.0-111-038	LOT/SEC-3	$ 5,051.76	$ 5,051.76
2.		ALL LT 2 & ALL LT 3	$	$
3.		BK 2659-1974	$	$
4.	10-31.0-104-025	LOT/SEC-8-BLK/RG-1	$ 294.64	$ 294.64
5.		BK 2659-1974	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,346.40	$ 5,346.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL REINFRCD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1986	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1986		$ 385,000	$	30	$ 12,833	$ 12,833	$ 227,786	4
5			1987		1,500		10			1,500	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	ROOFING			1990	2,168		10			2,168	10
11											11
12	ROOFING			1993	2,550		10			2,550	12
13											13
14	ROOFING			1998	3,600	360	10	360		2,220	14
15											15
16	FLOORING			1999	5,346	268	20	268		1,470	16
17											17
18	FIRE SYSTEM			1999	1,352	54	25	54		280	18
19											19
20	ROOFTOP A/C			2000	3,650	730	5	730		3,163	20
21											21
22	BATHROOM IMPV/SUMP PUMP			2002	3,943	394	10	394		1,183	22
23											23
24	GENERATOR			2002	11,084	554	20	554		1,524	24
25											25
26	REMODEL NURSES STATION			2002	1,998	133	15	133		344	26
27											27
28	5-TON FURNACE & AC			2002	4,526	302	15	302		729	28
29											29
30	UPGRADE KATOLIGHT GENERATOR			2002	5,541	277	20	277		531	30
31	SW SECTION ROOF			2003	6,269	627	10	627		940	31
32	NEW WATER HEATER			2004	1,133	113	10	113		113	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 439,660	$ 3,812		$ 16,645	$ 12,833	$ 246,501	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 25,698	$ 1,664	$ 1,664	$	VARIOUS	$ 19,631	71
72	Current Year Purchases	1,816	199	199		VARIOUS	199	72
73	Fully Depreciated Assets							73
74	SCRAPPED	(1,368)					(1,368)	74
75	TOTALS	$ 26,146	$ 1,863	$ 1,863	$		$ 18,462	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRAVEL	1995 FORD WINDSTAR	1995	$ 17,138	$	$	$	3	$ 17,138	76
77										77
78										78
79										79
80	TOTALS			$ 17,138	$	$	$		$ 17,138	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 522,944	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,675	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,508	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 282,101	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	ARCHITECTURAL DRAW.	$ 3,387	92
93			93
94			94
95		$ 3,387	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY LEASE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 1,480 Description: DISHWASHER
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	24	$ 2,535	$	24	$ 2,535	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		89	4,120		89	4,120	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	113	$ 6,655	$	113	$ 6,655	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,222	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,500)	104,406		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,640		6
7	Other Prepaid Expenses	13,923		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM REL PARTIES	46,102		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 245,293	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	53,160		15
16	Equipment, at Historical Cost	43,284		16
17	Accumulated Depreciation (book methods)	(52,814)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	3,387		22
23	Other(specify): DEPOSITS/EMP ADVANCES	2,225		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 49,242	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 294,535	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 114,853	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,992		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,134		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,050		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	38,522		35
	Other Current Liabilities(specify):			
36	DUE TO REL PARTIES	1,044,026		36
37	PATIENT FUNDS PAYABLE	14,616		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,250,193	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,250,193	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (955,658)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 294,535	$	48

***(See instructions.)**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (719,551)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (719,551)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(236,107)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (236,107)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (955,658)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 738,573	1
2	Discounts and Allowances for all Levels	(12,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 725,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,504	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 12,504	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,584	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 739,992	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	207,708	31
32	Health Care	505,902	32
33	General Administration	200,362	33
	B. Capital Expense		
34	Ownership	43,461	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	18,666	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 976,099	40
41	**Income before Income Taxes (line 30 minus line 40)****	(236,107)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (236,107)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN ON CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,249	1,365	$ 25,189	$ 18.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,673	1,827	34,554	18.91	3
4	Licensed Practical Nurses	7,230	8,048	130,609	16.23	4
5	Nurse Aides & Orderlies	15,829	17,083	170,583	9.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,643	1,769	19,396	10.96	8
9	Activity Director	2,048	2,224	24,481	11.01	9
10	Activity Assistants	50	50	444	8.88	10
11	Social Service Workers	1,509	1,656	15,794	9.54	11
12	Dietician					12
13	Food Service Supervisor	2,267	2,379	27,869	11.71	13
14	Head Cook	2,557	2,617	19,441	7.43	14
15	Cook Helpers/Assistants	1,716	1,771	11,894	6.72	15
16	Dishwashers					16
17	Maintenance Workers	943	964	7,888	8.18	17
18	Housekeepers	3,051	3,377	30,090	8.91	18
19	Laundry	1,830	1,937	16,704	8.62	19
20	Administrator	1,749	1,925	39,248	20.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	45,344	48,992	$ 574,184 *	$ 11.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	56	$ 2,073	1.3	35
36	Medical Director	48	5,350	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	84	942	11.3	44
45	Social Service Consultant	24	942	12.3	45
46	Other(specify)	24			46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	$ 9,907		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	47	$ 1,732	10.3	50
51	Licensed Practical Nurses	991	30,019	10.3	51
52	Nurse Aides	619	11,455	10.3	52
53	TOTAL (lines 50 - 52)	1,657	$ 43,206		53

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY KEENAN	ADMINISTRATOR	0	$ 39,248
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 39,248

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE		$
CENTERS, INC	MGMT FEES	11,640
BKD, LLP	ACCOUNTING	3,208
VAN OSTRAND & ELVIDG	LEGAL	385
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 15,233

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,544
Unemployment Compensation Insurance	
FICA Taxes	51,660
Employee Health Insurance	14,349
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	2,625
401K CONTRIBUTIONS	494
HOME OFFICE ALLOCATIONS	3,573
TOTAL (agree to Schedule V, line 22, col.8)	$ 107,245

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	771
Health Care Worker Background Check (Indicate # of checks performed 0)	
DUES AND SUBSCRIPTIONS	255
TAXES AND LICENSES	1,196
ADVERTISING OTHER	1,636
HOME OFFICE ALLOCATIONS	47
Less: Public Relations Expense	( )
Non-allowable advertising	(857)
Yellow page advertising	(779)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,269

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	277
Seminar Expense	1,237
HOME OFFICE ALLOCATIONS	1,286
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,800

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WEST MAIN NURSING HOME # 0031757 Report Period Beginning: 10/1/03 Ending: 9/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-8 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **18,666**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **NO**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **86%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.